

City of McMinnville Ambulance Service
Patient Request for Access to Protected Health Information

Patient Name: _____ Date _____

Address: _____

City: _____ State: _____ Zip Code: _____

Social Security Number: _____ ODL _____
(for patient identification purposes)

Date(s) of Service: _____ Phone # to reach Pt: _____

Patient Rights: As a patient, you have the right to access, copy or inspect your protected health information, or PHI, in accordance with federal law. You may also have the right to request an amendment to your PHI, or request that we restrict the use and disclosure of it. These rights are further described in our Notice of Privacy Practices and in other policies, which you may have upon request.

Please indicate the type of request you are making on this form: (check all that apply).
Requests will be given to patient or sent to the above address unless indicated below.

_____ Access to review my health information

_____ Access to obtain copies of my health information

_____ Access to review and potentially request amendment of my health information.

_____ Access to review and potentially request an accounting of how my PHI has been used and disclosed to others.

_____ Access to review and potentially request restrictions on the use and disclosure of my health information.

_____ Please send copies of my health information to this alternate address:

Signature _____ Request Date _____

Print Name _____

Please return to: City of McMinnville Ambulance Service
175 East 1st Street
McMinnville, Oregon 97128